CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT

All of the following information is required in order for medical equipment to be covered. This form must be contained in the recipient's clinical records.

RECIPIENT NAME:_____ MEDICAL ASSISTANCE ID NUMBER: _____

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DIAGNOSIS - INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS EQUIPMENT REQUEST: (an example of this requirement would be a diagnosis of cerebral palsy - problem being unable to ambulate and wheelchair bound)

_____
_____
_____
_____

PROGNOSIS: _____
_____
_____

HOW LONG IS THIS PROBLEM EXPECTED TO LAST? MONTHS__ INDEFINITELY__ PERMANENTLY__

EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR CONTINUED RENTAL:

_____
_____
_____

EQUIPMENT BEING PRESCRIBED: _____
_____
_____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

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EXPLANATION OF THE EQUIPMENT'S FUNCTION: (to include identifying information such as brochures and pictures)

_____
_____
_____

$_____ $_____
Purchase Price Rental Price/day-week-month-other

DME PROVIDER NAME AND ADDRESS: _____

DME PROVIDER IDENTIFICATION NUMBER: _____

DME CONTACT PERSON: _____